



South Dakota Board of Nursing  
4305 S. LOUISE AVENUE SUITE 201 ♦ SIOUX FALLS, SD 57106-3115  
(605) 362-2760 ♦ Fax: 362-2768 ♦ [www.state.sd.us/doh/nursing](http://www.state.sd.us/doh/nursing)

### UMA Endorsement Application

If any of the information is incorrect, incomplete or illegible, processing may be delayed. An applicant will be notified if additional information is required. **Mail this completed application to the address listed above or email to [Ashley.Kroger@state.sd.us](mailto:Ashley.Kroger@state.sd.us).**

**\*Allow up to 5-7 business days for the SDBON to process your application, upon approval the BON will email the approved proctor the access information to allow you to take the SDBON online exam.\***

Please Print

Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Other names previously used: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Street/PO Box

Telephone: Home: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_ Other: ( ) \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Gender: ☐ Male ☐ Female

Ethnicity: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Other

#### 1. High school education information or equivalency information.

Name of High School or Equivalency Program	Location of School or Equivalency Program (City, State)	Year Diploma or Equivalency Received

#### 2. Medication Aide Equivalency Education Information.

- ☐ Attach a copy of a certificate of completion for Medication Aide Training Program that lists the name and location of the program, and date completed. The program must have been at least 20-hours in length; *and*
- ☐ Attach a copy of verification that you are actively registered as a medication aide on another state's medication aide registry.

#### 3. RN Attestation.

I, \_\_\_\_\_, RN verify that I completed 4-hours medication administration clinical/lab training with the individual identified on this application, that the applicant is capable of performing all the skills listed on the SD Board of Nursing's approved Skills Competency Checklist safely and competently, and that the applicant is eligible to take the medication aide exam.

RN Signature: \_\_\_\_\_ RN License #: \_\_\_\_\_ Date: \_\_\_\_\_

#### 4. SD Board of Nursing Approved Test Proctor Information.

Name of SDBON Approved Proctor:	Proctor's Phone:	Proctor's Email Address:

#### 5. Do you currently owe child support arrearages in the sum of \$1,000 or more? ☐ YES ☐ NO

If YES, contact South Dakota Department of Social Services to make arrangements prior to issuance of med aide registration.

#### 6. Affidavit

I, the undersigned, declare and affirm under the penalties of perjury that this application for registration in the state of South Dakota has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

Medication Aide Applicant Signature \_\_\_\_\_

Date \_\_\_\_\_